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ABSTRACT

A study of the health mandates placed on elementary and secondary education in Illinois was initiated in September 1981. Rules and regulations requiring health examinations, screening of vision, hearing, and dental status, and immunization against certain preventable communicable diseases were reviewed. Analysis focused on five study questions: (1) What desirable condition or outcome is called for by the mandate? (2) In the absence of the mandate would the condition or outcome be achieved? (3) Can the mandate yield the desired results? (4) Could desired results be achieved if the mandate were defined or implemented differently? and (5) Does the mandate reflect a compelling state interest? This report includes an historical perspective, a discussion of the study methodology, a discussion of the major issues relating to the mandates, a set of conclusions, and preliminary recommendations. Appendices include selections from the rules and regulations set forth by the School Code of Illinois, the State Board of Education, and the Illinois Department of Public Health. (JD)

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STUDENT HEALTH MANDATE REPORT

AND

PRELIMINARY RECOMMENDATIONS

ILLINOIS STATE BOARD OF EDUCATION

Walter Naumer, Jr., Chairman
State Board of Education

Donald G. Gill
State Superintendent of Education

U.S. DEPARTMENT OF EDUCATION
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A. Public Act 83-0015
Section 27-8.1 Health Examinations and Immunizations, The School Code of Illinois

B. State Board of Education
Rules and Regulations to Govern Health Examinations and Immunizations

C. Illinois Department of Public Health
Rules and Regulations Governing the Child Health Examination and Immunizations

D. Public Act 81-174. Child Hearing Test Act

E. Illinois Department of Public Health
Rules and Regulations of the Child Hearing Test Act

F. Illinois Department of Public Health
Rules and Regulations Pursuant to Vision Screening

STUDENT HEALTH MANDATE REPORT

AND

PRELIMINARY RECOMMENDATIONS

I. INTRODUCTION

In September 1981, the Illinois State Board of Education adopted, and directed State Superintendent Donald G. Gill to implement, a plan for the careful and deliberative study of the mandates placed on elementary and secondary education in the state. This action reflected recognition of the need to eliminate unnecessary or unproductive mandates and to increase decision making at the level nearest the delivery of educational service. At the same time, the Board cautioned against the hasty removal of statutory and regulatory mandates.

This preliminary report on the student health mandate is one of five topics under study in Phase II of the Board's plan. The other topics in Phase II include Transportation, Compulsory Attendance, Student Records, and School Calendar/School Day. Phase I, which was concluded in May 1983, included Special Education, Physical Education, Driver Education, Bilingual Education and the Instructional Program. A third phase is also scheduled under the plan.

The student health mandates are contained in Chapter 122, Article 27, Section 8.1 of The School Code of Illinois. This section calls for rules and regulations which the Department of Public Health is required to promulgate to govern provisions of the law. The mandate requires health examinations and vision screening for students entering school, and again prior to entering grades 5 and 9; and hearing screening for students in kindergarten and grades 1, 2 and 3. It also requires students to be immunized against certain preventable communicable diseases.

The analysis focused on the following five study questions which the Board directed staff to examine:

1. What desirable condition or outcome is called for by the mandate?

   An essential step in determining the necessity of a requirement is being able to determine that it is purposeful, seeks to improve an existing condition, or creates a new and desirable condition. A mandate should be clearly directed towards an end which is stated in such a manner that its achievement can be reasonably assessed.

2. Is there evidence that in the absence of the mandate the condition or outcome will not be achieved?

   In this context, evidence may consist primarily of historical or trend data in order to determine the likelihood of success in the absence of a requirement. One major factor for consideration could be the amount of time available for implementation; that is, whether the condition needs to be met by a certain date or whether it is of such a nature that time is not the driving factor.

3. As presently defined does (can) the mandate yield the desired result?

   While measuring results may be a relatively straightforward proposition, the more complex but necessary task of determining -- or attributing -- cause/effect must also be undertaken. The need exists to be reasonably assured that it is the mandate which yields the desired result and not other uncontrolled factors.

4. Could the mandate be defined and/or implemented differently and yield the desired result?

   The nature of the mandate and any required administrative mechanisms should be consistent with the most current and accepted research and professional experience. Regulations should be as simple and direct as possible and allow for efficient and effective use of resources.

5. Does the mandate reflect a compelling state interest?

   The state's interest in mandates can be based on such principles as equality, equity, efficiency, compliance with higher authority or health and safety. There can also be compelling interests that reflect the state's values in terms of required activities, experiences or settings. The maintaining or establishing of mandates should be tied directly to an identifiable need of the state to cause the required activity.

The report includes an historical perspective, a discussion of the study methodology, a discussion of the major issues relating to the mandate, a set of conclusions, and preliminary recommendations.

Following a period of public comment, final recommendations will be presented by the State Superintendent to the Planning and Policy Committee for action and submission to the full Board.

II. HISTORICAL BACKGROUND

School health services began to evolve in the early 1890's. Communicable disease was the leading cause of death at that time. Schools began providing health services, including school nursing services, in the hope of reducing the high incidence of communicable disease among school children.

Most school health legislation was prompted by increased awareness of the existence of national health problems. A 1920 White House Conference on Child Welfare and a 1930 White House Conference on Child Health Protection emphasized the need for comprehensive school health programs providing health education, health services and a healthful school environment. By 1965, 19 states had compulsory immunization laws. The later strengthening of state immunization laws was spearheaded by Secretary of Health, Education and Welfare Joseph P. Califano's National Immunization Initiative which was launched in 1977.

According to the National Center for Disease Control, all 50 states and the District of Columbia now have compulsory school immunization laws for most vaccine-preventable communicable diseases. Thirty-eight states have laws that apply to all children in grades kindergarten through 12. The remaining states, including Illinois, have laws which affect school entrants and/or selected grade levels but not the total enrollment. Most state laws include both public and nonpublic school students. Thirty-nine states also include requirements which apply to certain day-care facilities. According to the American School Health Association, fifteen states have laws requiring health examinations for students entering certain grades. Of those fifteen states, nine require health examinations only for students entering school for the first time. According to this same source, 25 states mandate vision screening and 27 states mandate hearing screening.

In Illinois the first successful effort to pass student health legislation took place in 1943, when an amendment (Section 523.4) was added to the Physical Education and Training Act. This section stated, in part, that "a physical examination prescribed by the Superintendent of Public Instruction with the aid and advice of the Department of Public Health shall be required of all pupils in the public elementary and secondary schools immediately prior to or upon entrance into first grade and not less than four years thereafter." In 1945, Section 523.4 was redesignated as Section 27-8 of The School Code of Illinois. In 1957, the requirements were extended to kindergarten students. In 1959, the phrase "not less than four years thereafter" was replaced with wording to specify examination at grade levels 5 and 9. At that time the Illinois Department of Public Health was made responsible for prescribing the physical examination components. In 1967 provisions of the mandate were extended to nonpublic school students.

Since 1947, the Society for the Prevention of Blindness, the State education agency and the Department of Public Health have jointly developed guidelines for implementation of vision screening in Illinois. In 1961, The School Code of Illinois was amended to require that vision screening tests be a part of the health examinations mandated for all pupils in public schools. Vision screening could be done by a registered nurse or other qualified persons. Any abnormalities were to be referred to a physician specializing in eye diseases or a licensed optometrist for examination. Rules and regulations on vision screening were developed by the Illinois State Board of Education.

The Child Hearing Test Act was signed into Illinois law in 1969. This Act was amended in 1979 to include vision screening, which had previously been part of the mandated health examination. It is now known as the Child Vision and Hearing Test Act. The Department of Public Health and the Illinois State Board of Education jointly developed rules and regulations. The responsibility to ensure statewide delivery of these screening services was given to the Illinois Department of Public Health.

Immunization requirements were first enacted, as a part of Section 27-8, in 1967. The law required immunization against measles, smallpox, tetanus, diphtheria, pertussis (whooping cough) and polio. In 1972, Section 27-8 was amended to remove the requirements for smallpox vaccinations. In addition, the Illinois Department of Public Health was required to promulgate rules and regulations regarding the required immunizations.

A most significant legislative change came in 1979 with an emphasis on compliance. This change was accomplished through the repeal of Section 27-8 and its replacement with the current Section 27-8.1. The legislation requires that all students show proof of compliance with the rules and regulations governing immunizations and health examinations or be excluded from school attendance until such time as they are in compliance. It requires each school district to report to the State Board of Education the immunizations and health examination status of all students. The legislation also requires the withholding of 10% of state aid payments from school districts reporting less than 80% compliance in the 1980-81 school year and less than 90% compliance in each school year thereafter. The payments are to be released to the districts upon proof of compliance. To date, no school district has been penalized under this requirement.

The 1979 law introduced a number of other changes. It now included hearing screening in addition to vision screening. The schedule for vision screening corresponds to the mandated schedule for health examinations. However, hearing screening is required for grades kindergarten, first, second and third. All references to specific communicable diseases were deleted from the law. The Illinois Department of Public Health was required to promulgate rules and regulations detailing the health examination and immunization requirements. The provisions of the mandate were extended to include students attending nursery schools operated by public and nonpublic schools and institutions of higher education.

Prior to 1979 the mandate permitted exemption from the requirements on constitutional or medical grounds. The 1979 legislation continued exemptions for medical reasons. Constitutional exemptions were limited to those based on religious grounds rather than general philosophical objections.

The rules and regulations from the Illinois State Board of Education governing the reporting of compliance and the withholding of state aid became effective September 1980. The Illinois Department of Public Health promulgated emergency rules and regulations to govern the health examination and immunization requirements for Section 27-8.1 in September 1980. The adopted "Rules and Regulations to Govern the Child Health Examination and Immunizations" became effective on January 29, 1981. The adopted "Rules and Regulations Governing Vision and Hearing Screening" became effective on August 30, 1982. (See Appendix for copies of the statute and regulations.)

Legislation approved in July 1983 (P.A. 83-0015) stated that the parents or guardians of a child excluded from school for noncompliance with the mandate are in violation of the state's truancy laws and subject to the penalties of those laws. Upon conviction the parent or guardian is subject to not more than 30 days imprisonment and/or fine of up to $500.

III. METHODOLOGY

In addition to the five study questions which serve as the framework for all the mandate studies, other issues specific to this mandate were identified. The analysis of the student health mandate covered all aspects of the law and regulations with the exception of cost. Since it has been assumed in the mandate studies that funding mechanisms should flow from policy rather than direct policy, the cost factor of implementing this mandate was deferred for study following adoption of policy recommendations.

Information regarding the mandate and related issues was reviewed and analyzed. Sources of information included:

1. Statutes and regulations,

2. Historical background material,

3. Data collected by the Illinois Department of Public Health and the Illinois State Board of Education,

4. Research reports,

5. Newspaper articles, and

6. Published and unpublished documents.

Selected references appears at the end of this report.

Limitations of the data should be noted. First, compliance data for the immunization and health examination portions of the mandate are determined from a survey of public and nonpublic schools; therefore, they contain the limitations inherent in any self-reported data. Second, immunization against mumps is not required, and survey respondents report the numbers of students protected against mumps only if this information is available. As a result, data on protection levels for mumps are incomplete. Third, while data are available to document the desired conditions and resulting impact of immunization, similar data are not available for health examinations.

IV. IDENTIFICATION OF ISSUES

In the course of the study and analysis three issues emerged from the overall framework of the mandates that deserve separate attention. They are (1) the sanctions contained within the law, (2) the equal protection of public and nonpublic school students, and (3) the requirement to report to the State Board of Education.

1. Are the sanctions regarding immunizations and health examinations appropriate and effective?

As of this year, the truancy sanction may be applied against parents or guardians whose children are excluded for noncompliance. However, the major sanctions still include penalties levied against students and public school districts.

Although every public school district has reported satisfactory compliance levels, health risks to children may still exist. School districts with a districtwide 90% compliance level can and do have individual school compliance levels from 56% to 100%. Yet, the school district can be judged to be in compliance and not subject to the financial sanction. Also, students in noncompliance can attend school for approximately 45 days before being excluded. Their attendance during that period undoubtedly results in unacceptable levels of risk for some students in the school. In addition, their subsequent exclusion after 45 days is disruptive to their educational program. Last, there are no sanctions in the law on nonpublic schools nor any uniform means for verifying nonpublic school compliance. Therefore, it is reasonable to conclude that the sanctions regarding noncompliance with the immunization and health examination requirements are neither appropriate nor effective.

2. Is equal protection assured for both public and nonpublic school students?

The mandate applies to all students in "public, private, or parochial" schools. However, reported levels of compliance are lower in Illinois nonpublic schools than in public schools. As of January 15, 1983, 13.3% of the nonpublic schools (200 schools with 19,709 student enrollment) did not report to the State Board of Education as required. Of the 86.7% which reported, 16.8% of those nonpublic schools (218 schools with 22,952 student enrollment) reported compliance levels below the 90% acceptable level for public school districts. These levels may pose an unacceptable health risk. Equal protection for students in both public and nonpublic schools is not assured in the mandate.

3. Is the requirement to report immunization and health examination data to the State Board of Education appropriate and effective?

The mandate requires that the number of children who have received the necessary immunization and health examinations, those who have not received the immunizations and examinations as required, and the number of children who are exempt from health examinations and immunization requirements on religious or medical grounds be reported to the State Board of Education by October 15 in the manner prescribed by the Board. This information must then be provided to the Department of Public Health for action.

There are several problems related to this requirement. First, the requirement to report these data to the State Board of Education and then to the Department of Public Health results in an unacceptable time delay. The extensive amount of information and aggregation at various levels results in the need for detailed editing, compilation, and processing, generally not completed until March. This means that the aggregated data cannot be made available to the Department of Public Health until the school year is almost over.

Further, public health officials and the State Board of Education do not rely on these data when they monitor schools for recognition purposes. They rely on individual school records maintained in the district.

It is the identification of the individual student who is not in compliance that is of primary and immediate concern. However, the financial sanction requires that data beyond the minimal be collected, i.e., numbers of students in compliance for various diseases and completion of health examinations. These data are then compared with those students in noncompliance, reported by school and then by school district (for public school children). Another less cumbersome procedure should be used to expedite the involvement of the Department of Public Health in identifying the students not in compliance.

A reporting procedure which identifies children directly to the Department of Public Health would result in less burdensome data collection and reporting for school officials and, more importantly, would allow for more timely attention to the problem. In other words, the State Board of Education is an unnecessary intermediary in the reporting process.

V. CONCLUSIONS

Data and other information gathered in this study were organized based upon the five questions posed by the State Board and the additional topical issues identified by staff. The conclusions reflect the analysis of the five questions as well as these additional issues.

1. What desirable condition or outcome is called for by the mandate?

   a) Immunization

   The stated purpose is that every child in Illinois shall be immunized against the preventable communicable diseases identified by the Illinois Department of Public Health. The implied purpose is to bring about the eventual elimination of these diseases, as well as a reduction in illnesses, handicaps and absenteeism associated with these communicable diseases. While these purposes are clearly important, they are not among those normally considered to be the primary purposes of schooling. Therefore, while requiring the cooperation of schools, these purposes should be accomplished with the least possible disruption of the educational process.

   b) Health Examination

   The stated purpose is that every child in Illinois shall have a health examination prior to entering school and again prior to entering the fifth and ninth grades. The implied purpose is to attain a high level of child health. It may also be hoped that early exposure to health care will result in the development of good health habits in children.

   c) Vision and Hearing Screening

   The stated purpose is that every child in Illinois shall have vision screening prior to entering school and prior to entering the fifth and ninth grades. In addition, hearing screening shall be done annually for preschool children in any public or private educational program or licensed child care facility; for children enrolled in any special education program; and for children in any public or private kindergarten, first, second or third grade. The implied purpose is to identify vision or hearing problems which can be remediated or for which special educational services need to be provided.

2. Is there evidence that in the absence of the mandate the condition or outcome will not be achieved?

   a) Immunization

   There is no available statistical evidence indicating what would occur in the absence of the mandate. There is evidence that polio and smallpox, as well as diphtheria and tetanus, were virtually eradicated prior to the 1979 revision of the mandate which imposed a financial penalty on schools. The incidence of mumps, which is

not covered by the mandate, has also been reduced in recent years. This reduction may be due in part to the availability of a single vaccine which protects against measles, mumps, and rubella.

b) Health Examination

There is no evidence available indicating what would occur in the absence of the mandate. An extensive search of the literature on the possible benefits or the necessity of a health examination resulted in only one pertinent article, in Consumer Reports of October 1980. The article states, "Examinations annually, or even more frequently, are... appropriate for children under 6 and people over 60. For most of the years in between, an annual checkup... is probably not necessary." A 1972 Resolution of the American School Health Association recommends that children obtain "an adequate medical appraisal at or near enrollment and thereafter when health conditions suggest the need." Inquiries made of the American Medical Association and the Illinois State Medical Society determined that neither organization has taken an official position regarding the necessity and/or desirability of maintaining the current requirement of three student health examinations.

It can be assumed that students are having health examinations, prior to entering school and prior to the fifth and ninth grades because of the mandate. At the same time, it can be reasonably assumed that most children receive or have access to routine medical attention. Therefore, the mandate may be unnecessary for the majority of the population. Schools have the authority under the mandate to require additional health examinations when deemed necessary.

It is also significant that more than two-thirds of the states have found it unnecessary to have this requirement and of the fifteen that do, nine require only one such examination.

c) Vision and Hearing Screening

The Illinois Department of Public Health is mandated under separate legislation to conduct vision and hearing screening as well as to promulgate (with the State Board of Education) the rules and regulations. Since vision and hearing problems directly affect educational achievement, it would be in the interest of schools to support continued vision and hearing screenings even if there were no mandate. However, such screening could impose a burden on schools without nursing staff unless the Department of Public Health continued to offer the screenings as part of its ongoing services.

3. As presently defined does (can) the mandate yield the desired result?

a) Immunization

Although the goal of having all children immunized against measles, diphtheria, pertussis, tetanus, polio, and rubella has not been

achieved, the statewide compliance level reported by school districts has been more than 90% for each of the diseases. The increases in reported protection levels may be due in part to an improvement in systematic recordkeeping and reporting as well as an actual increase in immunizations. Other factors may also be involved, such as increased public awareness of health issues, improved neonatal care, and expanded insurance coverage.

It is important to note that the mandate places a penalty on a school district with less than 90% districtwide compliance; however, individual schools within the district may be below 90%. In 1982, of the approximately 4261 public school attendance centers, 267 (6.3%) reported compliance levels of less than 90%. About 82.8% (221) of these attendance centers are located in Chicago, and the others are scattered throughout the state. Public health officials indicate that a compliance level below 90% in an individual attendance center does not provide an acceptable level of protection against outbreaks of disease.

Table 1 on the following page shows the percentages of children who are reported to be fully protected based on data submitted to the State Board of Education. In addition to the students reported to be fully protected, a very small percentage of children are unprotected and in compliance due to religious objection or medical reasons. In 1982, .2% of students were reported unprotected and in compliance because of religious objection. The percentage of students unprotected and in compliance due to medical reasons ranges from a high of 1.8% for rubella to .2% for diphtheria and tetanus.

Data collected by the Illinois Department of Public Health on the incidence of diseases are reported in Table 2.

TABLE 1
FULL PROTECTION LEVELS BY DISEASE*

	First Entrants		All Students		
	1978	1979	1980	1981	1982
Measles	86.0%	87.1%	95.5%	96.0%	97.1%
Rubella	83.7%	84.7%	95.0%	94.9%	95.9%
DPT or DT	77.3%	80.1%	93.1%	92.5%	92.1%
Polio	67.5%	73.2%	93.2%	91.5%	94.8%
Mumps	74.3%	77.8%	65.1%	61.8%	69.1%

* Data collected in the 1978 and 1979 school years included only children entering school for the first time (kindergarten or first grade). Data collected in 1980, 1981 and 1982 included children in all grades. There is no reason to assume that protection levels in 1978 and 1979 were any higher for children already in school than for children entering for the first time. In fact, indications were that they were lower for older students. Direct comparisons between years are not possible due to different student populations surveyed.

TABLE 2
CASES OF DISEASE REPORTED IN ILLINOIS FOR ALL AGES

	DIPHTHERIA	MEASLES	MUMPS	PERTUSSIS	POLIO	RUBELLA	TETANUS
1964	9	16931	14474	786	5	NA	NA
1965	3	4690	4881	512	3	NA	NA
1966	3	11555	6419	611	4	NA	NA
1967	1	1306	10651	580	1	NA	NA
1968	0	1442	5404	268	3	3332	9
1969	1	1106	3212	208	1	1800	13
1970	22	1704	2387	358	1	1803	8
1971	1	2204	5585	174	1	1369	5
1972	3	4654	3399	110	0	1163	8
1973	0	2162	2944	129	0	1264	3
1974	2	2259	1707	269	0	635	4
1975	0	1853	2887	101	0	648	6
1976	0	2385	2333	47	0	1376	0
1977	0	3992	2024	261	0	754	3
1978	0	1381	2100	260	0	1972	2
1979	0	1636	1250	320	2	370	2
1980	0	351	437	142	0	188	9
1981	0	24	343	88	0	125	6
1982	0	24	315	164	0	87	2

Reported cases of measles have been substantially reduced in Illinois in the last ten years. Almost 4000 cases were reported in 1977 while only 24 cases were reported in 1982. Reported cases of rubella have also decreased in the ten-year period. The highest number of reported cases was in 1978 (1,972 cases). The lowest number of reported cases was in 1982 (87). (Many of these diseases are cyclical in nature.)

Since the enforcement provisions were added to the mandate in 1979, there has been an increase in the reported protection level as well as a decrease in the number of reported cases of measles and rubella. Even though the reported protection level for mumps has decreased since 1979, the number of cases of mumps has continued to decrease. Since immunizations for mumps and reporting on such immunizations are both optional, the protection level is probably higher than reported and occurs without a mandate. There have been year-to-year variations in the number of reported cases of pertussis but little progress toward elimination of the disease. The largest number of reported cases in the past ten years was 320 in 1979. The lowest number was 47 in 1976. Since pertussis vaccination is not given to children past the sixth birthday, the school immunization requirements have limited effectiveness in reducing incidence of the disease.

Table 3 on the following page shows the numbers and percentages of reported cases by age range. The age range 5 through 19 is the closest approximation to the school-age years available (although many 5-year-olds and most 19-year-olds are not in school). It is apparent that a substantial percentage of vaccine-preventable communicable diseases occur before school age. If these diseases are to be eliminated, children must be immunized as early as medically feasible.

b) Health Examination

Although the stated goal of every child in specified grades obtaining a health examination has not been achieved, data reported to the State Board of Education indicate that in 1982 at least 95% of those students have done so. There is no direct evidence that the mandate is yielding the desired result of raising the general level of children's health. The mandate does not insure remediation of medical problems identified during the health examination.

TABLE 3
DISEASE CASES BY AGE

DISEASE	YEAR	5 to 19	PERCENT	UNDER 5	PERCENT	20 & OVER	PERCENT	UNKNOWN	PERCENT	TOTAL
MEASLES	1973	1205	55.74	850	39.32	24	1.11	83	3.84	2162
	1974	1225	54.23	854	37.80	27	1.20	153	6.77	2259
	1975	744	40.15	860	46.41	24	1.30	225	12.14	1853
	1976	1723	72.24	390	16.35	35	1.47	237	9.94	2385
	1977	2717	68.06	907	22.72	120	3.01	248	6.21	3992
	1978	785	56.84	434	31.43	109	7.89	53	3.84	1381
	1979	1186	72.49	305	18.64	71	4.34	74	4.52	1636
	1980	231	65.81	95	27.07	25	7.12	0	0.00	351
	1981	10	41.67	11	45.83	1	4.17	2	8.33	24
RUBELLA	1973	856	67.72	122	9.65	189	14.95	97	7.67	1264
	1974	467	73.54	92	14.49	36	5.67	40	6.30	635
	1975	467	72.07	69	10.65	57	8.80	55	8.49	648
	1976	753	54.72	66	4.80	126	9.16	431	31.32	1376
	1977	492	65.25	76	10.08	57	7.56	129	17.11	754
	1978	1174	59.53	70	3.55	586	29.72	142	7.20	1972
	1979	264	71.35	36	9.73	48	12.97	22	5.95	370
	1980	118	62.77	36	19.15	34	18.09	0	0.00	188
	1981	68	54.40	35	28.00	9	7.20	13	10.40	125
TETANUS	1973	0	0.00	0	0.00	1	33.33	2	66.67	3
	1974	0	0.00	0	0.00	4	100.00	0	0.00	4
	1975	0	0.00	1	16.67	3	50.00	2	33.33	6
	1976	0	0.00	0	0.00	0	0.00	0	0.00	0
	1977	0	0.00	0	0.00	2	66.67	1	33.33	3
	1978	0	0.00	0	0.00	2	100.00	0	0.00	2
	1979	0	0.00	0	0.00	2	100.00	0	0.00	2
	1980	4	44.44	0	0.00	5	55.56	0	0.00	9
	1981	0	0.00	0	0.00	6	100.00	0	0.00	6
PERTUSSIS	1973			DATA NOT AVAILABLE BY AGE.						129
	1974			DATA NOT AVAILABLE BY AGE.						269
	1975			DATA NOT AVAILABLE BY AGE.						101
	1976			DATA NOT AVAILABLE BY AGE.						47
	1977	87	33.59	143	55.21	24	9.27	7	2.70	261
	1978	61	23.64	151	58.53	38	14.73	10	3.88	260
	1979	64	20.00	216	67.50	19	5.94	21	6.56	320
	1980	39	27.46	93	65.49		0.00	0	0.00	142
	1981	22	25.00	62	70.45	1	1.14	3	3.41	88
POLIO*	1979	0	0.00	0	0.00	2	100.00	0	0.00	2

* ONLY CASES OF POLIO SINCE 1971.

c) Vision and Hearing Screening

The screening of vision and hearing would seem to be the component of the mandate most closely linked to the process of education. While provisions of these screenings is mandated, there are no requirements for followup on referrals made as a result of the screenings.

According to the 1982 annual report of the Illinois Department of Public Health's Vision and Screening Section, about 1,160,000 Illinois children received vision screening tests and 1,200,000 children received hearing screening tests last year. These figures include preschool children. These screenings were conducted by school health personnel trained by the Illinois Department of Public Health, by local public health departments and by Illinois Department of Public Health staff. About 21,000 children were given medical referrals for possible hearing problems. Approximately 56% of these referrals were completed. About 84,000 children were given medical referrals for possible vision problems. Approximately 52% of these referrals were completed.

The Illinois Department of Public Health can provide remediative services for sensory problems. These services are provided through clinics with the assistance of agencies such as the University of Illinois - Division of Services for Crippled Children, the Illinois Department of Mental Health and Developmental Disabilities, local health departments and cooperatives and local hospitals. Last year 3,104 children were seen in hearing clinics and 517 in eye clinics.

4. Could the mandate be defined and/or implemented differently and yield the desired result?

A number of problems have been identified by staff in the preparation of this report. Under current law there exist inequities between the requirements placed on public schools and those placed on nonpublic schools. Financial sanctions placed on public schools cannot be placed on nonpublic schools. While public school districts determine compliance levels on a districtwide basis, nonpublic schools do so as individual schools.

Unacceptable levels of protection against vaccine preventable disease are permitted under two circumstances. For approximately 45 days at the beginning of school, nonimmunized children are allowed to attend school. Furthermore, since compliance levels are determined on a districtwide basis in public schools, some schools may maintain unacceptable levels of protection throughout the school year.

Exclusion of students in noncompliance on October 15 causes an unnecessary disruption of their education.

Since vision and hearing problems may directly affect educational achievement, schools should assume a more active role in pursuing assurance of referrals.

Since the administration of the mandate should be a shared responsibility rather than primarily the responsibility of schools, unnecessary burdens on schools should be removed.

In light of these points, the mandate could be changed in a number of ways and yield the desired results.

-- The immunization requirements could be changed to eliminate the provision which allows students who are not in compliance with the mandate to begin school and requires that students who have not come into compliance by October 15 be excluded from school. Instead, students would be required to be in compliance by August 15. Since this earlier date would provide adequate time for children to be brought into compliance by the start of school, it could result in virtually total compliance without the current necessity of disrupting students' education.

   There are school districts which now have a local policy of not enrolling or not giving a class schedule to students who are not in compliance with the health regulations. Two such school districts, with enrollments of about 2300 and 5800 students, reported almost 100% compliance last year. This change would end the current situation where individual attendance centers have unacceptably low levels of compliance.

-- Children should obtain a health examination prior to entering school. Such an examination would be required to detect gross anomalies which could affect the education of the child. The significance of this examination to the educational process and the general well-being of the child is such that the existing exclusion and truancy provisions are appropriate. Subsequent health examinations may be desirable. Local school administrators should retain the authority to require additional examinations as they deem necessary.

-- Since the health of children is primarily the responsibility of parents or guardians rather than of schools, the financial penalty currently levied against school districts is not appropriate and should be removed. Penalties for noncompliance should be placed on parents or guardians.

-- Followup procedures to ensure the correction of problems identified during vision and hearing screening should be strengthened by revising the rules and regulations. Schools should have the responsibility to implement appropriate procedures to assure increased levels of followup to referrals.

These changes would contribute to the desired result of good health for children but would achieve that goal while minimizing disruption of their education.

5. Does the mandate reflect a compelling state interest?

In terms of the health of both the individual child and the general population, there is a compelling state interest in the retention of the student health mandate. However, the mandate should be modified to reflect a shared responsibility for schools rather than a primary responsibility and to impose sanctions more appropriate to assuring the effectiveness of the mandate.

VI. PRELIMINARY RECOMMENDATIONS FOR ACTION BY THE STATE BOARD OF EDUCATION

It is recommended that the State Board seek legislation to change the mandate in the following ways:

A. Immunization

1. Require all children in both public and nonpublic schools (with exceptions for those with medical and religious exemptions) to be in compliance with the immunization requirements of the mandate by August 15 of the year in which they first enter school in Illinois. Students would be allowed to enroll but not allowed to attend school until they are in compliance with this requirement. Parents of those who fail to comply would be subject to the penalties of the truancy provision of the current law.

2. Eliminate the financial penalties against school districts.

3. Eliminate the requirement regarding the reporting of data to the State Board of Education.

4. Require that the names of all students who are not in compliance and the names and addresses of their parents or guardians be reported by public and nonpublic schools to the Illinois Department of Public Health by a date certain and by a method prescribed by the Illinois Department of Public Health. Failure to report such information should lead to a reduction in recognition status for public school districts. Nonpublic schools failing to report should be subject to procedures leading to the loss of the right to operate in Illinois.

B. Health Examinations

1. Retain the health examination requirement prior to entering school, but eliminate the health examination requirements at the fifth and ninth grades.

2. Eliminate the financial penalties against school districts.

3. Eliminate the requirements regarding the reporting of data to the State Board of Education.

C. Vision and Hearing Screening

The State Board of Education should cooperate with the Illinois Department of Public Health to revise the "Rules and Regulations Governing Vision and Hearing Screening" to do the following:

1. Require that school districts establish and implement followup procedures which will ensure that reasonable efforts have been made to urge parent/guardian response to vision and/or hearing problems identified during the screening process; and

2. Require that the Illinois Department of Public Health provide school districts with information which will enable local school districts to successfully implement such followup procedures.

SELECTED REFERENCES

American School Health Association. "Resolution on School Health Services, 1972." In Compendium of American School Health Association Resolutions and Position Statements. Kent, Ohio: 1982.

American School Health Association. School Health in America. A Survey of State School Health Programs. Kent, Ohio: 1981.

Bureau of the Budget, Office of Planning, State of Illinois. Why Are Children Not Being Immunized? A Study of Parental Immunization Behavior. Springfield, Illinois: 1978.

Center for Disease Control. Selected Recommendations of the Public Health Service Advisory Committee on Immunization Practices. Atlanta, Georgia: 1977.

Cromwell, Gertrude E. The Nurse in the School Health Program. Philadelphia: W. B. Sanders Co., 1963.

"Current Trends. Childhood Immunization Initiative, United States - 5 year Follow-Up." Morbidity and Mortality Weekly Report, 31, 17 (May 7, 1982), 231-232.

Illinois Department of Public Health. Annual Report for Vision and Hearing Program. Springfield, Illinois: 1982.

Illinois Department of Public Health. Unpublished Data on Disease Incidence, 1964-1983.

Illinois State Board of Education. The Immunization of School Age Children in Illinois. Springfield, Illinois: 1980, 1981, 1982, and 1983.

Illinois State Board of Education, Illinois Department of Public Health, Illinois Society for the Prevention of Blindness. Vision Screening Guide. Springfield, Illinois: 1977.

"Immunization Law Real Pain for Schools." Aurora Beacon-News, October 26, 1980.

Koplan, Jeffrey P. Benefits, Risks and Costs of Viral Vaccines. Atlanta, Georgia: Center for Disease Control, 1980.

Robbins, K.B., A.D. Brandling-Bennett, and A.R. Hinman. "Low Measles Incidence: Association with Enforcement of School Immunization Laws." American Journal of Public Health, 71, 3 (March, 1981), 270-274.

"Those Costly Annual Physicals." Consumer Reports, October 1980, 601-606.

"Whooping Cough Vaccine Recommended." Springfield State Journal-Register, July 2, 1982.

RMF 3299o

APPENDICES

AN ACT to amend Sections 27-8.1, 34-53 and 34-54.1 of "The School Code", approved March 18, 1961, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Sections 27-8.1, 34-53 and 34-54.1 of "The School Code", approved March 18, 1961, as amended, are amended to read as follows:

(Ch. 122, par. 27-8.1)

Sec. 27-8.1. Health Examinations and Immunizations. (1) In compliance with rules and regulations which the Department of Public Health shall promulgate, and except as hereinafter provided, all children in Illinois shall have a health examination as follows:

Within one year prior to entering kindergarten or the first grade of any public, private or parochial elementary school; upon entering the fifth and ninth grades of any public, private, or parochial school; prior to entrance into any public, private or parochial nursery school; and, irrespective of grade, immediately prior to or upon entrance into any public, private, or parochial school, or nursery school, each child shall present proof of having been examined in accordance with this Section and the rules and regulations promulgated hereunder. Additional health examinations of pupils may be required when deemed necessary by school authorities.

(2) The Department of Public Health shall promulgate rules and regulations specifying the examinations and procedures which shall constitute a health examination.

Physicians licensed to practice medicine in all of its branches shall be responsible for the performance of the health examinations, other than dental examinations and vision and hearing screening, and shall sign all report forms required by subsection (4) of this Section, which pertain to

Approved July 5, 1983

PA 83-0015

those portions of the health examination for which he is responsible. If a registered nurse performs any part of an examination, then a physician licensed to practice medicine in all of its branches must review and sign all required report forms. Licensed dentists shall perform all dental exams and shall sign all report forms required by subsection 4 of this Section, which pertains to the dental exam. Vision and hearing screening tests shall be conducted in accordance with rules and regulations of the Department of Public Health, and by individuals which the Department of Public Health has certified.

(3) Every child shall, at or about the same time as he receives a health examination required by subsection (1) of this Section, present to the local school, proof of having received such immunizations against preventable communicable diseases as the Department of Public Health shall require by rules and regulations promulgated pursuant to this Section and "An Act in relation to the prevention of certain communicable diseases", approved July 5, 1967, as amended.

(4) The individuals conducting a health examination shall record the fact of having conducted the examination, and such additional information as required, on uniform forms which the Department of Public Health and the State Board of Education shall prescribe for statewide use. The examiner shall summarize on the report form any condition which he suspects indicates a need for special services. The individuals confirming the administration of required immunizations shall record as indicated on the form that the immunizations were administered.

(5) If a child does not submit proof of having had either the health examination or the immunization as required, then the child shall be examined or receive the immunization, as the case may be, and present proof by October 15 of the current school year; provided, if for medical reasons one or more of the required immunizations

must be given after October 15 of the current school year, then the child shall present, by October 15, a schedule for the administration of the immunizations and a statement of the medical reasons causing the delay, both the schedule and the statement being issued by the physician, registered nurse or local health department that will be responsible for administration of the remaining required immunizations. If a child does not comply by October 15 of the current school year with the requirements of this subsection, then the local school authority shall exclude that child from school until such time as the child presents proof of having had the health examination as required, and presents proof of having received those required immunizations which are medically possible to receive immediately. During a child's exclusion from school for noncompliance with this subsection, the child's parents or legal guardian shall be considered in violation of Section 26-1 and subject to any penalty imposed by Section 26-10.

(6) Every school shall report to the State Board of Education by October 15, in the manner which that agency shall require, the number of children who have received the necessary immunizations and the health examination as required, indicating, of those who have not received the immunizations and examination as required, the number of children who are exempt from health examination and immunization requirements on religious or medical grounds as provided in subsection (8). This reported information shall be provided to the Department of Public Health by the State Board of Education.

(7) Upon determining that the number of pupils who are required to be in compliance with subsection (5) of this Section is below 80% of the number of pupils enrolled in the school district on October 15, 1980, or is below 90% of the number of pupils enrolled in the school district on October 15, 1981 or any subsequent year, 10% of each State aid

payment made pursuant to Section 18-8 to the school district for such year shall be withheld by the regional superintendent until the number of students in compliance with subsection (5) is the applicable specified percentage or higher.

(8) Children whose parents or legal guardians object to health examinations or any part thereof, or to immunizations, on religious grounds shall not be required to submit their children or wards to health examinations or immunizations if such parents or legal guardians present to the appropriate local school authority a signed statement of objection, detailing the grounds for such objection. If the physical condition of the child is such that any one or more of the immunizing agents should not be administered, the examining physician responsible for the performance of the health examination shall endorse such fact upon the health examination form. Exempting a child from the health examination does not exempt him from participation in the program of physical education training provided in Sections 27-5 through 27-7 of this Code.

(9) For the purposes of this Section, 'nursery schools' means those nursery schools operated by elementary school systems or secondary level school units or institutions of higher learning.

STATE BOARD OF EDUCATION

TEXT OF ADOPTED RULES

1. By October 15, 1980, 80% of all enrolled pupils in each school district must meet Illinois Department of Public Health immunization requirements in each disease category and have had the Illinois Department of Public Health Examination for the school district to be in compliance with Par. 27-8.1 of The School Code of Illinois. Pupils who are exempt from health examination or immunization on religious or medical grounds shall be counted in compliance with the law. By October 15, 1981, 90% of all enrolled pupils must meet the foregoing requirement for the school district to be in compliance with Par. 27-8.1 of The School Code of Illinois.

2. On October 15 or the first school day thereafter if school is not in session on October 15, each school district shall conduct a survey of each attendance center in the district to determine the number of students in compliance with the immunizations and health examination requirements of Par. 27-8.1 of The School Code.

3. School districts shall by October 30 report to the State Board of Education the number of students who have received the necessary health examination and immunizations, the number of students who are not exempt and have not received the required immunizations and health examination and the number of students exempt from the health examination and immunization requirements for religious or medical reasons, on forms provided by the State Board of Education. A copy shall also be delivered to the Regional Superintendent.

4. Any school districts whose reports have not been mailed or delivered to the State Board of Education by October 30 will immediately be issued a Notice of Non-Compliance with Par. 27-8.1 and be given Notice of Opportunity of Hearing on Proposed 10% Reduction in State Aid Payment beginning November 20 and semi-monthly thereafter until compliance is documented.

5. By November 10, the State Board of Education shall determine from submitted reports, which districts should be cited for non-compliance with the percentage requirements of Par 27-8.1. The State Board of Education shall immediately issue Notices of Non-Compliance and Opportunity for Hearing on Proposed 10% Reduction in State Aid Payment beginning November 20 and semi-monthly thereafter until compliance levels are reached and documented.

6. The Regional Superintendent shall receive simultaneous notice of non-compliance for any districts located in the Educational Service Region.

7. The Notice of Opportunity for Hearing and all hearing procedures shall be in accordance with the Administrative Procedure Act, Chapter 127, Paragraph 1010, et seq., and the Illinois State Board of Education's Rules of Practice in Contested Cases and Other Formal Hearings.

STATE BOARD OF EDUCATION

TEXT OF ADOPTED RULES

8. The State Board of Education shall periodically audit districts to verify compliance levels furnished in the school districts' report. Any time such an audit reveals non-compliance, such notices of non-compliance and opportunity for hearing shall immediately be issued.

(filed September 5, 1980, effective September 5, 1980)

Rules and Regulations Governing the Child Health Examination and Immunizations

Rule 1.0 Statutory Authority

The Department of Public Health is authorized under Chapter 122, Paragraph 27-8.1 of the School Code of Illinois to "promulgate the rules and regulations, specify the examinations and procedures which shall constitute a health examination, and to promulgate rules and regulations specifying immunizations against preventable communicable diseases."
(filed January 29, 1981, effective January 29, 1981)

Rule 1.1

General Considerations-To abate the considerable confusion through the State as to several aspects of this law the Department of Public Health now promulgates rules in order to safeguard the health of school children in Illinois and to set the standards for the school health examination and immunizations pursuant to The School Code of Illinois, Chapter 122, Paragraph 27-8.1.
(filed January 29, 1981, effective January 29, 1981)

Rule 1.2

HEALTH EXAMINATION FOR ALL PUBLIC, PRIVATE/independent AND PAROCHIAL school students in Illinois shall require a physical examination, protection from communicable disease, and vision and hearing screening according to the following Rules and Regulations of the Illinois Department of Public Health. Dental examinations are recommended as part of the health examination, but not mandatory.
(filed January 29, 1981, effective January 29, 1981)

Rule 1.3

ALL PUBLIC, PRIVATE/independent AND PAROCHIAL SCHOOL STUDENTS ARE REQUIRED TO HAVE A HEALTH EXAMINATION PERFORMED AND SIGNED BY A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL OF ITS BRANCHES including (Medical Doctors or Doctors of Osteopathy). A PHYSICIAN IS REQUIRED TO REVIEW AND SIGN ANY PORTION OF THE HEALTH EXAMINATION COMPLETED BY A REGISTERED NURSE UNDER HIS AUTHORITY.
(filed January 29, 1981, effective January 29, 1981)

Rule 1.4

THE EXAMINATION SHALL BE CONDUCTED WITHIN ONE YEAR:

a. PRIOR TO THE DATE OF ENTERING SCHOOL (this includes nursery school, special education, headstart programs operated by elementary school

systems or secondary level school units or institutions of higher learning; and students transferring into Illinois from out-of-state or out-of-country);

b. PRIOR TO THE DATE OF ENTERING KINDERGARTEN OR FIRST GRADE;

c. PRIOR TO THE DATE OF ENTERING THE FIFTH GRADE;

d. AND AGAIN, PRIOR TO THE DATE OF ENTERING THE NINTH GRADE.

For students attending school programs where grade levels are not assigned, examinations shall be completed prior to the date of entering and within one year of the ages of 5, 10, and 14.

ADDITIONAL HEALTH EXAMINATIONS and further evaluations OF STUDENTS MAY BE REQUIRED WHEN DEEMED NECESSARY BY SCHOOL AUTHORITIES.
(filed January 29, 1981, effective January 29, 1981)

Rule 1.5

HEALTH EXAMINATIONS SHALL BE REPORTED ON THE UNIFORM FORMS THE DEPARTMENT OF PUBLIC HEALTH AND THE ILLINOIS STATE BOARD OF EDUCATION PRESCRIBE FOR STATEWIDE USE. Effective December 1, 1980, the required form is the Certificate of Child Health Examination, and compliance in using this form shall be required as of the 1981-82 school year and every school year thereafter. The Certificate of Child Health is the prescribed form and filed as Appendix A to this rule.

a. For transfer students from out-of-state or out-of-country, a health form that is comparable to the Illinois requirements may be accepted only at the time of first entry into an Illinois school. (A statement by a physician or health care provider indicating only that an examination had been conducted is not acceptable.)

b. The physical examination shall include an evaluation of: height, weight, skin, eyes, ears, nose, throat, throat/dental, cardiovascular (including blood pressure), respiratory, gastrointestinal, genito-urinary, neurological, muscular skeletal system, scoliosis examination, nutritional status, and other evaluations deemed necessary by the examiner. The strongly recommended evaluations include hemoglobin, hematocrit, urinalysis, lead screening and sickle cell. It also recommended the examiner list any medications the child takes routinely, diet restrictions/needs, special equipment needed, or known allergies.

c. THE EXAMINER SHALL SUMMARIZE ON THE REPORT FORM ANY CONDITION HE/SHE SUSPECTS INDICATES A NEED FOR SPECIAL SERVICES.

d. The medical history section of the form shall be completed and signed by the parent or legal guardian of the student. The medical history shall be inclusive as indicated on the Certificate of Child Health Examination form.

e. The individual verifying the administration of required immunizations shall record as indicated on the Certificate of Child Health Examination form that the immunizations were administered as required by current Rules and Regulations of the IDPH and the Rules and Regulations of this Act.

f. Vision and hearing screening is required under the Child Vision and Hearing Test Act and Rules and Regulations prescribed thereunder. (Public Act 81-174). Completion of the vision and hearing data section of the Certificate of Child Health Examination is optional.

g. If the vision and hearing screening data section is completed, it shall be completed with information provided by the vision and hearing screening personnel certified by the IDPH/OR from qualified medical or other professional specialists.

h. If the student is required to have a sports physical that coincides in the year with the child health examination requirement, the Child Health Examination form may be accepted as proof of examination for interscholastic sports if the statement regarding participation in interscholastic sports is completed by the examiner.

(filed January 29, 1981, effective January 29, 1981)

Rule 1.6

Every student is required to present proof to the local school authority of having had the health examination in accordance with Rule 1.4 and these Regulations prior to the date of entrance to school.

(filed January 29, 1981, effective January 29,1981)

Rule 2.1

EVERY CHILD SHALL PRESENT ON OR ABOUT THE SAME TIME AS HE/SHE RECEIVES A HEALTH EXAMINATION PROOF TO THE LOCAL SCHOOL AUTHORITY OF HAVING RECEIVED SUCH IMMUNIZATIONS AS THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH SHALL REQUIRE BY CURRENT RULES AND REGULATIONS.

(filed January 29, 1981, effective January 29, 1981)

Rule 2.2

Local school authority is defined as that person having ultimate control and responsibility for any public, private/independent, parochial

elementary or secondary school or attendance center or nursery school operated by an elementary or secondary school or institution of higher learning.
(filed January 29, 1981, effective January 29, 1981)

Rule 2.3

SCHOOL ENTRANCE

a. EVERY CHILD, PRIOR TO ENTERING ANY PUBLIC, PRIVATE/independent or PAROCHIAL SCHOOL IN ILLINOIS shall present to that school proof of immunity against:

Diphtheria
Pertussis
Tetanus
Poliomyelitis
Measles
Rubella

b. The health care provider verifying the administration of the required immunization shall record as indicated on the Certificate of Child Health Examination that the immunizations were administered.

c. Any child who does not submit proof of having protection by immunity as required must receive the needed vaccine. If for medical reasons one or more of the required immunizations must be given after the date of entrance of the current school year, a schedule for the administration of the immunizations and a statement of the medical reasons causing the delay must be signed by the health care provider who will administer the needed immunizations and be kept on file at the local school.
(filed January 29, 1981, effective January 29, 1981)

Rule 2.4

BASIC IMMUNIZATION

a. Any child 5 years of age or younger entering school for the first time must show proof (dates see 2.5b) of having received four or more doses of DPT with the last dose being a booster and having been received on or after the 4th birthday, but prior to school entrance; or within one year prior to school entrance. Individual doses in the series must have been received no less than four weeks apart.

Any child 6 years of age or older must show proof (dates see 2.5b) of receiving three or more doses of DPT or Td with the last dose being a

booster and having been received on or after the 4th birthday. Individual doses in the series must have been received no less than four weeks apart.

If 10 years have elapsed since the last booster, an additional booster is required.

b. Any child 5 years of age or younger entering school for the first time must show proof (dates see 2.5b) of having received three or more doses of TOPV with the last dose being a booster and having been received on or after the 4th birthday but prior to school entrance. Individual doses in the series must have been received no less than six weeks apart.

Any child 6 years of age or older must show proof (dates see 2.5b) of receiving three or more doses to TOPV with the last dose being a booster and having been received on or after the 4th birthday. Individual doses in the series must have been received no less than six weeks apart.

A series of inactivated poliovirus vaccine (IPV) and appropriate boosters may, for an individual, be substituted for vaccination with TOPV at the direction of a physician.

c. Any child two years of age or older entering at any grade level must show proof (dates see 2.5b) of receiving measles vaccine at 15 months of age or older. (Until school year 1981-82, twelve months of age is acceptable for those children entering kindergarten or first grade). Proof (dates) of disease, if verified by a physician, may be substituted for proof of vaccination. See Rule 2.5(c).

If immunization was received prior to 1968, proof must be provided that a live virus vaccine was given.

d. All children 2 years of age or older entering school at any grade level must show proof (dates see 2.5b) of receiving rubella vaccine on or after the 1st birthday. Proof of disease is not acceptable unless laboratory evidence is presented with blood titer of 1:16 (or equivalent titer) or greater.

Females 10 years of age or older are not required to receive rubella vaccine as a condition of school attendance. It is recommended that all females age 10 or older who are not immune to rubella receive the vaccine; however, it should be administered only where the necessary individual medical evaluation and supervision can be provided.

(filed January 29, 1981, effective January 29, 1981)

Rule 2.5

PROOF OF IMMUNITY

a. Proof of immunity shall be documented evidence of having received vaccine or proof of disease (as described below) verified by a health care provider defined as: physician, school health professional, or health official.

b. Day and month is required if it can not otherwise be determined that the vaccine was given after the minimum interval or age.

c. Proof of prior measles disease must be verified with date of illness signed by a physician or laboratory evidence of immunity by an antibody titer of 1:16 (or equivalent titer) or greater.

d. The only acceptable proof of immunity for rubella is evidence of vaccine (dates rule 2.5b) or laboratory evidence of a blood titer of 1:16 (or equivalent titer) or greater.

e. When the proof of immunity requirements set forth in Rule 2.5(a) cannot be supplied by a health care provider, this rule may be satisfied, in school year 1980-81 only, by the parent or legal guardian of the child executing a signed sworn statement setting forth the information required under Rule 2.5(a) which would otherwise be verified by a health care provider as defined in that rule.

(filed January 29, 1981, effective January 29, 1981)

Rule 2.6

BOOSTER IMMUNIZATIONS

Those booster immunizations prescribed in Rule 2.4 are required.
(filed January 29, 1981, effective January 29, 1981)

Rule 2.7

A child shall be considered in compliance with the law if all immunizations which a child can medically receive are given prior to entering school and a signed statement from a health care provider is presented indicating when the remaining medically indicated immunization will be received. Immunization schedules must be monitored by local school authorities to assure completion of the immunization schedule. If a child is delinquent for a scheduled appointment for immunization he/she is no longer considered to be in compliance.
(filed January 29, 1981, effective January 29, 1981)

Rule 2.8

A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL OF ITS BRANCHES, who believes a child to be protected against a disease for which immunization is required may so indicate in writing, stating the reasons, and certify that he/she believes the specific immunization in question is not necessary or indicated. Such a statement should be attached to the child's school health record and accepted as satisfying the medical exception provision of the regulation for that immunization. These statements of lack of medical need will be reviewed by the Illinois Department of Public Health with appropriate medical consultation.
(filed January 29, 1981, effective January 29, 1981)

Rule 3.1

VISION AND HEARING SCREENING TESTS SHALL BE CONDUCTED IN ACCORDANCE WITH THE PRESENT RULES AND REGULATIONS OF THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH.
(filed January 29, 1981, effective January 29, 1981)

Rule 4.1

It is strongly recommended that a dental examination be performed on all public, private/independent, and parochial school students by a licensed dentist.
(filed January 29, 1981, effective January 29, 1981)

Rule 4.2

If a dental examination is performed, it shall BE CONDUCTED WITHIN ONE YEAR:

a. PRIOR TO the date of ENTERING SCHOOL (nursery school, special education, head start programs, OPERATED BY ELEMENTARY SCHOOL SYSTEMS OR SECONDARY LEVEL SCHOOL UNITS OR INSTITUTIONS OF HIGHER LEARNING; and students transferring into Illinois schools from out-of-state or out-of-country);

b. PRIOR TO the day of ENTERING KINDERGARTEN/FIRST GRADE;

c. PRIOR TO the date of ENTERING THE FIFTH GRADE;

d. And again PRIOR TO the date of ENTERING THE NINTH GRADE.

e. For students attending school programs where grade levels are not assigned examinations shall be completed prior to the date of entering and within one year prior to the age of 5, 10 and 14.

Additional dental examinations of students may be required when deemed necessary by school authorities.
(filed January 29, 1981, effective January 29, 1981)

Rule 4.3

If performed, the dental examination shall be recorded on the Dental Examination Record prescribed by the Illinois Department of Public Health for statewide use and presented to the local school authority. The Dental Examination Record is the prescribed form by the Illinois Department of Public Health and filed as appendix B to this rule.
(filed January 29, 1981, effective January 29, 1981)

Rule 4.4

If the dental examination is performed, it shall be inclusive as indicated on the Dental Examination Record and with the Department of Public Health Dental Health Guidelines.
(filed January 29, 1981, effective January 29, 1981)

EXCEPTIONS

Rule 5.1

PARENT OR LEGAL GUARDIAN OF A STUDENT MAY OBJECT TO HEALTH EXAMINATIONS, IMMUNIZATIONS, VISION AND HEARING SCREENING TESTS, AND DENTAL HEALTH EXAMINATIONS FOR THEIR CHILDREN ON RELIGIOUS GROUNDS. IF A RELIGIOUS OBJECTION IS MADE, A WRITTEN AND SIGNED STATEMENT FROM THE PARENT OR LEGAL GUARDIAN DETAILING SUCH OBJECTIONS MUST BE PRESENTED TO THE LOCAL SCHOOL AUTHORITY. General philosophical or moral reluctance to allow physical examinations, immunizations, vision and hearing screening, and dental examinations will not provide a sufficient basis for an exception to statutory requirements. The parent or legal guardian must be informed by the local school authority of measles outbreak control exclusion procedures per IDPH Rules and Regulations for the Control of Communicable Diseases (Chapter 111 1/2, Paragraph 22, Illinois Revised Statutes, 1977) at the time such objection is presented.)
(filed January 29, 1981, effective January 29, 1981)

Rule 5.2

ANY MEDICAL OBJECTION TO AN IMMUNIZATION MUST BE: 1) MADE BY A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL ITS BRANCHES INDICATING WHAT THE MEDICAL CONDITION IS, 2) ENDORSED AND SIGNED BY THE PHYSICIAN ON THE CERTIFICATE OF CHILD HEALTH EXAMINATION AND PLACED ON FILE IN THE CHILD'S PERMANENT RECORD. Should the condition of the child later permit immunization, this requirement will then have to be met. Parents or legal

guardians must be informed of measles outbreak control exclusion procedures when such objection is presented per 5.1.
(filed January 29, 1981, effective January 29, 1981)

PLEASE PRINT/TYPE

CERTIFICATE OF CHILD HEALTH EXAMINATION

(INFORMATION ON THIS FORM MAY BE SHARED WITH APPROPRIATE PERSONNEL FOR HEALTH AND EDUCATIONAL PURPOSES)

PUPIL'S NAME: _____ (LAST / FIRST / MIDDLE) BIRTHDATE _____ (MO DAY YR) SEX ☐ M ☐ F GRADE LEVEL: _____

ADDRESS: _____ (STREET / CITY / ZIP CODE) PARENTS TELEPHONE: _____ / _____ (HOME / WORK) SCHOOL: _____

PARENT OR GUARDIAN: _____ ADDRESS: _____

MEDICAL HISTORY

TO BE COMPLETED BY PARENT

CHICKEN POX . . . . . YEAR: _____

SCARLET FEVER/STREP . . . . YEAR: _____

T.B. / T.B. CONTACT. . . . . YEAR: _____

CONGENITAL DEFECTS . . . . . _____

DIABETES. . . . . _____

EPILEPSY. . . . . _____

HEART DISEASES . . . . . _____

FREQUENT EAR INFECTION . . . _____

INJURIES/ACCIDENTS . . . . . YEAR: _____

RESULTS _____

PERMANENT DISABILITY . . . . YEAR: _____

TYPE _____

RESULTS _____

SURGERY (OPERATIONS). . . . . YEAR: _____

TYPE _____

RESULTS _____

ALLERGIES (LIST) _____

ROUTINE MEDICATIONS (LIST) _____

OTHER _____

PARENT'S SIGNATURE DATE

IMMUNIZATION

PLEASE PROVIDE THE MONTH DAY AND YEAR FOR EVERY DOSE ADMINISTERED. THE DAY AND MONTH IS REQUIRED IF YOU CANNOT DETERMINE IF THE VACCINE WAS GIVEN PRIOR TO THE MINIMUM INTERVAL OR AGE.

DOSE	1 MO	1 DAY	1 YR	2 MO	2 DAY	2 YR	3 MO	3 DAY	3 YR	4 MO	4 DAY	4 YR	5 MO	5 DAY	5 YR
DIPHTHERIA, PERTUSSIS AND TETANUS (DPT)															
DIPHTHERIA AND TETANUS (Td) OR (TD)															
ORAL POLIO															
COMBINED MEASLES/MUMPS/ RUBELLA (MMR)															
COMBINED MEASLES AND RUBELLA (MR)															
RUBEOLA (RED MEASLES) LIVE VIRUS VACCINE															
RUBELLA (3DAY OR GERMAN MEASLES)															
MUMPS															
*TB SKIN TEST						RESULTS									

*MANDATED FOR CHILD CARE FACILITIES

HEALTH PROVIDER SIGNATURE (PHYSICIAN, SCHOOL HEALTH PROFESSIONAL OR HEALTH OFFICIAL) (VERIFYING THAT IMMUNIZATIONS WERE GIVEN)

SIGNATURE DATE

SIGNATURE DATE

SIGNATURE DATE

1. CLINICAL DIAGNOSIS IS ACCEPTABLE IF VERIFIED BY PHYSICIAN.

MEASLES _____ (MONTH / DAY / YEAR)

MUMPS _____ (MONTH / DAY / YEAR)

2. LABORATORY CONFIRMATION OF ANY DISEASE IS ACCEPTABLE.

DISEASE _____

_____ (MONTH / DAY / YEAR)

_____ LAB RESULT

PHYSICIAN'S SIGNATURE DATE

PHYSICAL EXAMINATION

TO BE COMPLETED BY PHYSICIAN

EVALUATION: (REQUIRED)

	NORMAL	ABNORMAL	FOLLOW-UP – COMMENT
HEIGHT _____ WEIGHT _____			
SKIN			
EYES			
EARS			
NOSE			
THROAT			
THROAT/DENTAL			
CARDIOVASCULAR B/P _____			
RESPIRATORY			
GASTROINTESTINAL			
GENITO-URINARY			
NEUROLOGICAL			
MUSCULAR SKELETAL			
SCOLIOSIS SCREENING			
NUTRITIONAL STATUS			
OTHER _____			

(STRONGLY RECOMMENDED)

	DATE	NORMAL	ABNORMAL RESULTS
HEMOGLOBIN			
HEMATOCRIT			
URINALYSIS			
LEAD SCREENING			
SICKLE CELL			

MEDICATIONS _____

DIET RESTRICTION / NEEDS _____

SPECIAL EQUIPMENT NEEDED _____

ALLERGIES _____

OTHER _____

GENERAL COMMENTS _____

ON THE BASIS OF THIS EXAMINATION ON THIS DAY I APPROVE THIS CHILD'S PARTICIPATION IN: IF NO, PLEASE ATTACH EXPLANATION.

INTERSCHOLASTIC SPORTS (FOR 1 YEAR) ☐ YES ☐ NO

PHYSICAL EDUCATION ☐ YES ☐ NO

PHYSICIAN'S SIGNATURE _____ DATE: _____

ADDRESS _____ TELEPHONE: _____

VISION AND HEARING SCREENING DATA

THIS SECTION TO BE COMPLETED BY I.D.P.H. CERTIFIED SCREENING PERSONNEL – IF PRE-EXISTING APPROVED FORM BY I.D.P.H. IS NOT AVAILABLE.

PRE-SCHOOL – DURING FIRST YEAR OF ENROLLMENT SCHOOL AGE – DURING SCHOOL YEAR AT REQUIRED GRADE LEVEL

DATE																				
GRADE																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
VISION																				
HEARING																				

CODE

P – PASS

F – FAIL

R – REFERRED

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ILLINOIS STATE BOARD OF EDUCATION
ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES
ILLINOIS HIGH SCHOOL ASSOCIATION.

IDPH • ISBE • DCFS • IHSA • 001.2 • 10/80

DENTAL EXAMINATION RECORD

INFORMATION ON THIS FORM MAY BE SHARED WITH APPROPRIATE PERSONNEL FOR HEALTH AND EDUCATIONAL PURPOSES.

TO BE COMPLETED BY THE PARENT: *(THIS PORTION ONLY)*

PUPIL'S NAME: LAST	FIRST	MIDDLE	BIRTH DATE MONTH DAY YEAR

ADDRESS: STREET	CITY	ZIP CODE	TELEPHONE:

NAME OF SCHOOL:	GRADE LEVEL	SEX: ☐ MALE ☐ FEMALE

PARENT OR GUARDIAN:	ADDRESS:

1. IS YOUR CHILD RECEIVING FLUORIDE TREATMENTS IN SCHOOL? ☐ YES ☐ NO COMMENT _____

2. DOES YOUR CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE DENTAL TREATMENT? (i.e., ALLERGIES, DIABETES, RESPIRATORY DIFFICULTY, HISTORY OF RHEUMATIC FEVER, ETC.) ☐ YES ☐ NO EXPLAIN _____

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

- ☐ URGENT – (ABSCESS FORMATION, NERVE EXPOSURE, ADVANCED DISEASE STATE INCLUDING HANDICAPPED INDIVIDUALS)
- ☐ ROUTINE DENTAL CARE NEEDED – (ALLOYS, COMPOSITES, STAINLESS STEEL CROWNS, ETC.)
- ☐ PREVENTIVE DENTISTRY ONLY NEEDED – (PROPHYLAXIS, FLUORIDE TREATMENT, SEALANTS, ETC.)
- ☐ NO TREATMENT REQUIRED
- ☐ OTHER _____

PATHOLOGY PRESENT

HARD TISSUE ☐ YES ☐ NO DESCRIBE _____

SOFT TISSUE ☐ YES ☐ NO DESCRIBE _____

MALOCCLUSION ☐ YES ☐ NO TYPE _____

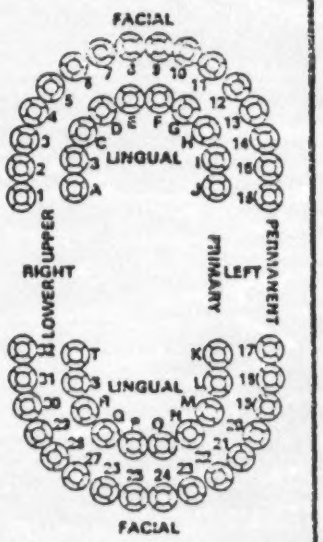
ORTHODONTIC REFERRAL RECOMMENDED ☐ YES ☐ NO

SIGNATURE OF DENTIST: _____ DATE: _____

ADDRESS: _____
STREET CITY ZIP CODE

TELEPHONE:

OPTIONAL



OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY / LOCATION
BLOCK IN FILLINGS PRESENT

PLEASE PRINT OR STAMP

IDPH • DCA/M 3/80

CHAPTER 23 — CHARITIES & PUBLIC WELFARE

CHILD HEARING TEST ACT

AN ACT authorizing the Department of Public Health to establish and administer a program of vision and hearing screening services for children in Illinois and designating powers and duties with respect thereto. P.A. 76-1571, approved and eff. Sept. 25, 1969. Title amended by P.A. 81-174, § 2, approved and eff. Aug. 13, 1979.

2331. Citation

§ 1. This Act shall be known as and may be cited as the "Child Vision and Hearing Test Act".

Amended by P.A. 81-174, § 1, eff. Aug. 13, 1979.

2332. Definitions

§ 2. As used in this Act, unless the context otherwise requires, the following words and phrases mean:

"Department" is the Department of Public Health;

"Director" is the Director of the Department of Public Health;

"Vision and Hearing Screening Services" are the identification, testing, evaluation and initiation of follow-up services as defined in the rules and regulations of the Department and the State Board of Education, as required by Section 4.[1]

Amended by P.A. 81-174, § 1, eff. Aug. 13, 1979.

[1] Paragraph 2334 of this chapter.

2333. Vision and hearing screening services

§ 3. Vision and hearing screening services shall be administered to all children as early as possible, but no later than their first year in any public or private education program, licensed day care center or residential facility for handicapped children; and periodically thereafter, to identify those children with vision or hearing impairments or both so that such conditions can be managed or treated.

Amended by P.A. 81-174, § 1, eff. Aug. 13, 1979.

2334. Establishment of program—Rules and regulations

§ 4. In addition to the program of hearing screening services established by the Department under this Act, the Department shall establish a program of vision screening services by January 1, 1980. The Department and the State Board of Education shall jointly develop rules and regulations governing standards, procedures, techniques and criteria for conducting and administering vision and hearing screening services and shall set standards for the training and qualifications of personnel to provide such services.

Amended by P.A. 81-174, § 1, eff. Aug. 13, 1979.

2335. Powers and duties of department

§ 5. In administering the program of vision and hearing screening services, the Department shall not replace any qualified existing service, and shall:

(a) Provide consulting services, to local health departments, school districts, or other community agencies who establish or supplement programs for vision and hearing screening services.

(b) Delegate responsibility to other State agencies, local health departments, school districts, or other community agencies, to develop and maintain periodic vision and hearing screening services.

(c) Provide direct services through contractual arrangement for the development and maintenance of periodic vision and hearing screening services.

(d) Accept reports of vision and hearing evaluations from qualified medical or other professional specialists employed by parents or guardians for vision and hearing evaluations when such reports are submitted to the Department.

Amended by P.A. 81-174, § 1, eff. Aug. 13, 1979.

2336. Objection to test

§ 6. No child shall be required to submit to any test required by this Act if a parent or a guardian of the child objects on constitutional grounds, and submits a written statement of such objection to the agency administering such vision and hearing screening services.

Amended by P.A. 81-174, § 1, eff. Aug. 13, 1979.

2337. Advisory committees

§ 7. The Director shall appoint a Children's Hearing Services Advisory Committee and a Children's Vision Services Advisory Committee. The membership of each committee shall not exceed 10 individuals. In making appointments to the Children's Hearing Services Advisory Committee, the Director shall appoint individuals with knowledge of or experience in the problems of hearing handicapped children and shall appoint at least two licensed physicians who specialize in the field of otolaryngology and are recommended by that organization representing the largest number of physicians licensed to practice medicine in all of its branches in the State of Illinois, and at least two audiologists. In making appointments to the Children's Vision Services Advisory Committee, the Director shall appoint two members (and one alternate) recommended by the Illinois Society for the Prevention of Blindness, two licensed physicians (and one alternate) who specialize in ophthalmology and are recommended by that organization representing the largest number of physicians licensed to practice medicine in all of its branches in the State of Illinois, and two licensed optometrists (and one alternate) recommended by that organization representing the largest number of licensed optometrists in the State of Illinois, as members of the Children's Vision Services Advisory Committee. The Children's Hearing Services Advisory Committee shall advise the Department in the implementation and administration of the hearing services program and in the development of rules and regulations pertaining to that program. The Children's Vision Services Advisory Committee shall advise the Department in the development of rules and regulations pertaining to that program. Each committee shall select a chairman from its membership and shall meet at least once in each calendar year.

The members of the Advisory Committees shall receive no compensation for their services, however, the nongovernmental members shall be reimbursed for actual expenses incurred in the performance of their duties in accordance with the State of Illinois travel regulations.

Amended by P.A. 81-174, § 1, eff. Aug. 13, 1979.

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER j: VISION AND HEARING

PART 675
HEARING SCREENING

SUBPART A: AUTHORITY, APPLICABILITY AND DEFINITIONS

SECTION
675.10 Applicability
675.20 Definitions

SUBPART B: STANDARDS, PROCEDURES, TECHNIQUES AND CRITERIA FOR HEARING SCREENING

675.100 Instrumentation
675.110 Frequency of Screening
675.120 Identification Audiometry
675.130 Referral Criteria
675.140 Referral

SUBPART C: GENERAL STANDARDS FOR TRAINING AND QUALIFICATIONS FOR PERSONNEL TO PROVIDE HEARING SCREENING SERVICES

675.200 Screening Personnel

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AUTHORITY: Implementing Sections 3, 4, and 5 and authorized by Section 4 of the Child Vision and Hearing Test Act. (Ill. Rev. Stat. 1981, ch. 23, pars. 2333, 2334 and 2335)

SOURCE: Adopted and codified 6 Ill. Reg 10998, effective August 30, 1982.

SUBPART A: AUTHORITY, APPLICABILITY AND DEFINITIONS

Section 675.10 Applicability

a) The Child Vision and Hearing Test Act requires hearing screening services be administered to all children. These rules apply to hearing screening services required under that Act.

b) The Department shall delegate responsibility to other State agencies, local health departments, school districts, or other community agencies, to develop and maintain periodic vision and hearing screening services. The Department shall make such delegations in conformance with existing services and with the approval of the entity receiving the delegation.

Section 675.20 Definitions

As used in these rules, the terms defined in this section shall have the meanings ascribed to them herein.

"Department" means the Illinois Department of Public Health.

"Hearing screening" means on-going programs of:

Community education regarding the identification, prevention, cause, nature and effects of hearing impairments,

Identification audiometry, and

Referral procedures.

SUBPART B: STANDARDS, PROCEDURES, TECHNIQUES AND CRITERIA FOR HEARING SCREENING

Section 675.100 Instrumentation.

a) Pure-tone audiometers utilized for identification audiometry must comply with minimum specifications established by the American National Standards Institute as published in the American National Standard Specifications for Audiometers. (ANSI - 53.6-1969)

b) Pure-tone audiometers utilized for identification audiometry must undergo an electro-acoustic coupler calibration check a minimum of once per calendar year. The electro-acoustic calibration check shall include the following measurements:

1) frequency count;

2) attenuator linearity; and

3) earphone sound pressure level output.

c) This calibration service is to be supervised and provided through programs developed by the Department, as provided for in the Department's Audiometer Calibration Standards which are on file with the Secretary of State.

Section 675.110 Frequency of Screening

a) Hearing screening services shall be provided annually for all preschool children three years of age or older in any public or private educational program or licensed child care facility.

b) Hearing screening services in public, independent, private and parochial schools shall be provided annually for all children in grades kindergarten, 1, 2, and 3, and after grade 3 for teacher referrals and students transferring into schools who have not been previously screened.

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c) In lieu of the screening services required in paragraphs (a) and (b) of this section; a completed and signed report form, indicating a professional ear examination by a physician licensed to practice medicine in all of its branches has been administered not over 12 months previously, is acceptable.

d) Hearing screening services in public, independent, private and parochial schools shall be provided annually for all special education children screened using screening methods contained in Section 675.120 of these rules.

e) The parent or legal guardian of a student may object to hearing screening tests for their children on religious grounds. If a religious objection is made, a written and signed statement from the parent or legal guardian detailing such objections must be presented to the local school authority. General philosophical or moral reluctance to allow hearing screening will not provide a sufficient basis for an exception to statutory requirements.

Section 675.120: Identification Audiometry

a) Screening Procedures

1) For the screening stage of identification audiometry, the following pure-tone frequencies and intensity levels shall be used:

Test Frequencies in Cycles Per Second	Screening Levels in Decibels
500 Hz	25 dB
1000 Hz	25 dB
2000 Hz	25 dB
4000 Hz	25 dB

2) If a child fails to hear any tone at 25 dB, you should immediately raise the level to 35 dB and present it again. If the child responds at the 35 dB level, move on to the next test frequency and present the tone at 25 dB. In the event the child's condition is such that recommended screening procedures are not applicable, the child should receive alternative services if the child is considered at risk for hearing difficulties.

b) Pass - Fail Criteria

1) A child is considered to have "failed" the screening test, if he:

A) fails to hear any tone at 35 dB in either ear; or

B) fails to hear any two tones at 25 dB in the same ear.

2) Children "failing" the screening test should be given a second screening identical to the first and judged by the same criteria. The second screening should occur within two weeks of the first test. Those children who fail the second screening should then have a threshold test.

c) Threshold Test Procedures

It is recommended that the right ear be tested first. Always begin testing at 1000 Hz. After determining threshold at 1000 Hz, continue with the following frequencies: 2000, 4000, 8000, 500 and 250 Hz. Then switch to the opposite ear and repeat the entire procedure at 1000, 2000, 4000, 8000, 500 and 250 Hz.

Section 675.130: Referral Criteria

a) A child is considered to have "failed" the threshold test and is referred for a medical examination and an educational screening evaluation if either or both of the following criteria are met:

1) Any two speech frequencies (500-1000-2000 Hz) in the same ear which fall on or below the referral line, or

2) Any two consecutive frequencies in the same ear which fall on or below the referral line (250-500, 2000-4000 or 4000-8000 Hz).

b) The referral line is at 30 dB for the frequencies 500, 1000, and 2000 Hz and at 40 dB for the frequencies 250, 4000 and 8000 Hz.

Section 675.140: Referral

a) Medical evaluation must be immediately recommended in written form to the parents or guardians of all children who meet the referral criteria as a result of threshold screening testing. The referral criteria is set forth in Section 675.130 of these rules. These same children must be made known to the local education agency (LEA) or its designee for audiological review.

b) The screening agent or its designee shall initiate recommendations for medical evaluation and shall coordinate those activities necessary to complete medical management of the child suspected of a hearing impairment.

SUBPART C: GENERAL STANDARDS FOR TRAINING AND QUALIFICATIONS FOR PERSONNEL TO PROVIDE HEARING SCREENING SERVICES

Section 675.200: Screening Personnel

Hearing screening shall be provided by a technician trained and certified by the Department. A certificate will be presented following successful completion of the course. This certificate is valid for a three-year period, and can be renewed each three years by attending a recertification workshop. A valid certificate in hearing as defined by the Department is contingent on the following:

a) Any person with a high school education or its equivalent who is working in or supervising or has a definite commitment to work in or supervise a hearing screening program may apply for training. The screening program must be for identification of hearing problems in preschool and school age children.

b) Full attendance at the hearing training course is mandatory.

c) Successful completion of a written examination at the conclusion of the lecture series. A score of 75 percent or greater must be obtained, or the trainee will be failed.

d) Demonstration of proficiency at a hearing practicum. This phase includes: the ability to instruct and test children; the ability to recognize screening failures and referrals; and the ability to successfully organize and maintain the hearing screening program. Failure to successfully demonstrate proficiency at the practicum portion of the workshop will result in the trainee being categorized into one of the following groups:

1) "pass with further supervision" - this category will allow the trainee to pass the course after demonstration of proficiency through an additional supervisory visit(s) by the regional hearing consultant of the Department;

2) "failure to demonstrate proficiency" - the category indicates the trainee did not meet expectations and will not be certified to perform hearing testing.

e) Curriculum

The training course involves intensive instruction and practice time. The curriculum shall include but is not limited to the following:

1) Hearing impairment and the philosophy of hearing conservation.

2) Basic anatomy and physiology of the hearing mechanism.

3) Disorders of hearing.

4) Introduction to hearing testing and test equipment.

5) The hearing threshold and the audiogram.

6) Hearing screening practicum.

Appendix F

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
NOTICE OF ADOPTED RULEMAKING FOR CODIFICATION

Agency: Illinois Department of Public Health

Title or Name of Rules and Action Taken by Agency:

Rules and Regulations Pursuant to Vision Screening 77 Ill. Adm. Code 685.

Statutory Authority:

Ill. Rev. Stat. 1981, ch. 23, par. 2334

Effective Date of Rules:

August 30, 1982

Date Filed in Agency's Principal Office:

August 30, 1982

Date Notice of Proposal Published in Register:

April 30, 1982

Has the Joint Committee on Administrative Rules issued a Statement of Objections to this/these Rules? (If answer is yes, list date Agency's response appeared in Illinois Register)

No

Difference between proposal and final version:

These rules had only one major change to them. The State Board of Education asked that a sentence be added to Section 685.20(b) that will read "The Department shall make such delegations in conformance with existing services and with the approval of the entity receiving the delegation" and one was a change brought about by the Joint Committee that allows screening services to be waived if a professional ear examination by a physician licensed to practice medicine in all of its branches has been administered not over 12 months previously.

Will this rulemaking replace an emergency rule currently in effect?

No

Is the State Library's Certificate of Review and Approval for compliance with the codification system attached to these rules?

Yes

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
NOTICE OF ADOPTED RULEMAKING FOR CODIFICATION

Date codification system compliance required?

October 1, 1984

Summary and Purpose of Rules:

P.A. 81-174 amended certain sections of the Child Vision and Hearing Test Act. Because of these amendments and with the advice of the Children's Hearing Services Advisory Committee these rules are being adopted.

Information and answers to questions regarding this adopted rule shall be directed to:

Mr. Robert Hedges, Chief, Division of Governmental Affairs, Department of Public Health, 535 West Jefferson, Springfield, Illinois 62761, 217/782-6187.

The full text of Adopted Rules is as follows:

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TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER j: VISION AND HEARING

PART 685
VISION SCREENING

SUBPART A: AUTHORITY, APPLICABILITY AND DEFINITIONS

SECTION
685.10 Applicability
685.20 Definitions

SUBPART B: STANDARDS, PROCEDURES, TECHNIQUES AND CRITERIA FOR VISION SCREENING

685.100 Instrumentation
685.110 Frequency of Screening
685.120 Referral

SUBPART C: GENERAL STANDARDS, CRITERIA AND PROCEDURES FOR SCHOOL VISION SCREENING

685.200 Screening Battery
685.210 Screening and Rescreening Procedures
685.220 Pass/Fail and Referral Criteria

SUBPART D: GENERAL STANDARDS, CRITERIA, AND PROCEDURES FOR PRESCHOOL VISION SCREENING

685.300 Screening and Rescreening Procedures
685.310 Pass/Fail and Referral Criteria

SUBPART E: GENERAL STANDARDS FOR TRAINING AND QUALIFICATIONS FOR PERSONNEL TO PROVIDE VISION SCREENING SERVICES

685.400 Screening Personnel

AUTHORITY: Implementing Sections 3, 4, and 5 and authorized by Section 4 of the Child Vision and Hearing Test Act. (Ill. Rev. Stat. 1981, ch. 23, pars. 2333, 2334, and 2335)

SOURCE: Adopted and codified at 6 Ill. Reg 11053, effective August 30, 1982.

SUBPART A: AUTHORITY, APPLICABILITY AND DEFINITIONS

Section 685.10 Applicability.

a) The Child Vision and Hearing Test Act requires vision screening services be administered to all children. These rules apply to vision screening services required under that Act.

b) The Department shall delegate responsibility to other State agencies, local health departments, school districts, or other community agencies, to develop and maintain periodic vision and hearing screening services. The Department shall make such delegations in conformance with existing services and with the approval of the entity receiving the delegation.

Section 685.20 Definitions.

As used in these rules, the terms defined in this section shall have the meanings ascribed to them herein.

"Department" means the Illinois Department of Public Health.

"Eye doctor" means a physician licensed to practice medicine in all its branches and specializing in diseases of the eye or a licensed optometrist.

"Vision Screening" means a procedure for detecting possible abnormality of the visual system with referral for correction, treatment, or appropriate school placement.

SUBPART B: STANDARDS, PROCEDURES, TECHNIQUES AND CRITERIA FOR VISION SCREENING

Section 685.100 Instrumentation

Instruments for screening pre-school age children are those which measure distance visual acuity. Instruments for screening school age children are those which are capable of measuring the following:

a) Visual acuity

b) Hyperopia

c) Muscle balance

d) Optional tests

Section 685.110 Frequency of Screening

a) Vision screening services under these rules shall be provided annually for:

1) All preschool children 3 years of age (or older) in any public or private educational program or licensed child-care facility.

2) All children in grades kindergarten or first, 5th and 9th grades of public, independent, private and parochial schools.

3) Teacher referrals and students transferring into schools who have not been previously screened.

4) All special education children in public, independent, private, and parochial schools using standard screening methods as set forth in these rules.

b) In lieu of the screening services required in paragraph (a) above, of this Section, a completed and signed report form, indicating a professional eye examination by an M.D. specializing in diseases of the eye or a licensed optometrist has been administered not over 12 months previously, is acceptable.

c) The parent or legal guardian of a student may object to vision screening tests for their children on religious grounds. If a religious objection is made, a written and signed statement from the parent or legal guardian detailing such objections must be presented to the local school authority. General philosophical or moral reluctance to allow vision screening will not provide a sufficient basis for an exception to statutory requirements.

Section 685.120 Referral

a) Based on the criteria set forth in Sections 685.220 and Section 685.310, any observed anomaly or possible problem identified through instrument screening shall be reported in writing to the child's parent or legal guardian.

b) The parents or legal guardians shall be recommended through written notification to obtain a vision diagnostic examination for their child if a professional eye examination has not been secured within the previous 12 months.

c) The vision diagnostic examination shall be made by an eye doctor of the parents or guardian's choice.

d) The screening agency or its designee shall be responsible to initiate follow-up services.

SUBPART C: GENERAL STANDARDS, CRITERIA AND PROCEDURE FOR SCHOOL VISION SCREENING

Section 685.200 Screening Battery

The appropriate battery of tests and order of presentation shall consist of:

a) Observation of the child.

b) A series of tests which are conducted in a prescribed order as follows:

1) A test for Phoria at the Near and Far points;

2) A test for Visual Acuity;

3) A test for Excessive Farsightedness (Hyperopia); and

4) Optional Tests.

Section 685.210 Screening and Rescreening Procedures

a) Observation of the child is to determine the appearance of the eyes, behavior of the child for signs of unusual visual symptoms, and/or complaints by the child regarding vision difficulties.

b) Management on Screening Day of Children Wearing Glasses or Under Care: The Illinois Department of Public Health recommends children wearing glasses should not be screened.

c) Screening Tests:

1) Phoria Near

The test is conducted in a binocular mode with the instrument set for the Near presentation of the target.

2) Phoria Far

The test is conducted in a binocular mode with the instrument set for the Far presentation of the target.

3) Visual Acuity

The test is conducted in a monocular mode, always beginning with the right eye. The instrument is set for the presentation of the target at the Far position.

4) Hyperopia

The instrument is set for a Far presentation of the target and the Plus Lens in place. The test is conducted in a monocular mode, always beginning with the right eye.

d) Rescreening procedures are identical to the initial screening and conducted following a 10-14 day delay.

Section 685.220 Pass/Fail and Referral Criteria

a) School children shall be screened at the 20/30 line.

b) Pass/Fail criteria shall refer to the initial screening test. Referral criteria shall refer to the rescreening test. The Pass/Fail and Referral Criteria are identical standards presented in Paragraphs c) through e) below, of this section.

c) Phoria Near and Far

1) For children in first grade, target alignment outside a defined area for both Near and Far modes shall constitute a failure.

2) For children in second grade and above, target alignment outside a defined area for either Near or Far Modes shall constitute a failure.

d) Visual Acuity

The correct identification of 3 or less of the monocular symbols constitutes a failure.

e) Hyperopia

The correct identification of four or more of the monocular symbols constitutes a failure.

SUBPART D: GENERAL STANDARDS, CRITERIA, AND PROCEDURES FOR PRESCHOOL VISION SCREENING

Section 685.300 Screening and Rescreening Procedures

a) Observation of the child shall be conducted in accordance with Section 685.210(a).

b) The instrument screening of the child is visual acuity in a monocular mode at the Far position only. Always begin with the right eye.

c) Preschool rescreening procedures are identical to the initial screening and should be conducted following a 10-14 day delay.

d) Preschool screening procedures shall be applicable to testing the difficult-to-test child including the mentally handicapped, learning disabled, foreign speaking, hearing handicapped, etc. In the event the child's condition is such that recommended screening procedures are not applicable, the child should receive alternative services if the child is considered at risk for visual difficulties.

Section 685.310 Pass/Fail and Referral Criteria

a) Preschool children shall be screened at the 20/40 line.

b) Visual Acuity: The correct identification of 3 or less of the monocular symbols constitutes a failure.

SUBPART E: GENERAL STANDARDS FOR TRAINING AND QUALIFICATIONS FOR PERSONNEL TO PROVIDE VISION SCREENING SERVICES

Section 685.400 Screening Personnel

Vision screening shall be provided by a technician trained and certified by the Department. A certificate will be presented following successful completion of the course. This certificate is valid for a three-year period, and can be renewed each three years by attending a recertification workshop. A valid certificate in vision as defined by the Department is contingent on the following:

a) Any person with a high school education or its equivalent who is working in or supervising or has a definite commitment to work in or supervise a vision screening program may apply for training. The screening program must be for identification of vision problems in preschool and school age children.

b) Full attendance at the vision training course is mandatory.

c) Successful completion of a written examination at the conclusion of the lecture series. A score of 75 percent or greater must be obtained, or the trainee will be failed.

d) Demonstration of proficiency at a vision practicum. This phase includes: the ability to instruct and test children; the ability to recognize screening failures and referrals; and the ability to successfully organize and maintain the vision screening program. Failure to successfully demonstrate proficiency at the practicum portion of the workshop will result in the trainee being categorized into one of the following groups:

1) "pass with further supervision" - this category will allow the trainee to pass the course after demonstration of proficiency through an additional supervisory visit(s) by the regional vision consultant of the Department;

2) "failure to demonstrate proficiency" - the category indicates the trainee did not meet expectations and will not be certified to perform vision testing.

e) Curriculum

These training courses are offered as a program involving intensive instruction and practice time. The curriculum shall include but is not limited to the following:

1) Vision program philosophy.

2) Organizing and conducting a vision screening program.

3) Approved methods of screening.

4) Standards for screening and referral.

5) Vision screening referral.